Exhibit 3

IN THE UNITED STATES BANKRUPTCY COURT
FOR THE DISTRICT OF DELAWARE

In re:	)	Chapter 11
	)	
W. R. GRACE & CO., et al.,	)	Case No. 01-01139 (JKF)
	)	Jointly Administered
Debtors.	)	
	)	

W. R. Grace
Asbestos Personal Injury
Questionnaire

YOU HAVE RECEIVED THIS PROOF OF CLAIM/QUESTIONNAIRE BECAUSE GRACE BELIEVES THAT YOU HAD SUED ONE OR MORE OF THE DEBTORS LISTED IN APPENDIX A ATTACHED TO THIS QUESTIONNAIRE BEFORE GRACE FILED FOR BANKRUPTCY ON APRIL 2, 2001 FOR AN ASBESTOS-RELATED PERSONAL INJURY OR WRONGFUL DEATH CLAIM, AND THAT CLAIM WAS NOT FULLY RESOLVED.

IF YOU HAVE SUCH A CLAIM, YOU MUST COMPLETE AND SUBMIT THIS QUESTIONNAIRE BY [DATE] TO RUST CONSULTING, INC., THE CLAIMS PROCESSING AGENT, AT ONE OF THE FOLLOWING ADDRESSES:

RUST CONSULTING, INC.
CLAIMS PROCESSING AGENT
RE: W.R. GRACE & CO. BANKRUPTCY
P.O. BOX 1620
FARIBAULT, MN 55021

(IF SENT BY U.S. MAIL)

RUST CONSULTING, INC.
CLAIMS PROCESSING AGENT
RE: W.R. GRACE & CO. BANKRUPTCY
201 S. LYNDALE AVE.
FARIBAULT, MN 55021

(IF SENT BY FEDERAL EXPRESS, UNITED PARCEL SERVICE, OR A SIMILAR HAND DELIVERY SERVICE)

A QUESTIONNAIRE (AND ANY AMENDMENTS OR ADDITIONAL DOCUMENTS IN SUPPORT OF THE QUESTIONNAIRE) WILL NOT BE CONSIDERED UNLESS RECEIVED BY RUST CONSULTING, INC. BY [DATE].

THIS QUESTIONNAIRE IS AN OFFICIAL DOCUMENT, APPROVED BY THE COURT. YOU SHOULD READ THIS QUESTIONNAIRE IN ITS ENTIRETY AND FOLLOW ALL OF ITS INSTRUCTIONS. FAILURE TO DO SO MAY HAVE SIGNIFICANT CONSEQUENCES, INCLUDING: (1) YOUR BEING FOREVER BARRED FROM ASSERTING OR RECEIVING PAYMENT ON ACCOUNT OF YOUR CLAIM; AND (2) YOUR CLAIM BEING VALUED AT ZERO FOR PURPOSES OF PAYING AND ESTIMATING ASBESTOS-RELATED PERSONAL INJURY AND WRONGFUL DEATH CLAIMS AS A WHOLE.

THE ASSESSMENT OF GRACE'S LIABILITY FOR ASBESTOS-RELATED PERSONAL INJURY AND WRONGFUL DEATH CLAIMS, INCLUDING YOURS, WILL UTILIZE, AND ULTIMATELY MAY BE BASED SOLELY UPON, THE INFORMATION PROVIDED IN RETURNED QUESTIONNAIRES.

DEFINITIONS AND INSTRUCTIONS

A. GENERAL

1. This Questionnaire refers to any lawsuit that you filed before April 2, 2001 for an "asbestos-related personal injury or wrongful death claim." This term is intended to cover any lawsuit alleging any claim for personal injuries or damages that relates to: (a) exposure to any products or materials containing asbestos that were manufactured, sold, supplied, produced, specified, selected, distributed or in any way marketed by one or more of the Debtors (or any of their respective past or present affiliates, or any of the predecessors of any of the Debtors or any of their respective past or present affiliates), or (b) exposure to vermiculite mined, milled or processed by the Debtors (or any of their respective past or present affiliates, any of the predecessors of any of the Debtors or any of their predecessors' respective past or present affiliates). It includes claims in the nature of or sounding in tort, or under contract, warranty, guarantee, contribution, joint and several liability, subrogation, reimbursement, or indemnity, or any other theory of law or equity, or admiralty for, relating to, or arising out of, resulting from, or attributable to, directly or indirectly, death, bodily injury, sickness, disease, or other personal injuries or other damages caused, or allegedly caused, directly or indirectly, and arising or allegedly arising, directly or indirectly, from acts or omissions of one or more of the Debtors. It includes all such claims, debts, obligations or liabilities for compensatory damages such as loss of consortium, personal or bodily injury (whether physical, emotional or otherwise), wrongful death, survivorship, proximate, consequential, general, special, and punitive damages.

2. Your Questionnaire will be deemed filed only when it has been actually received by Rust Consulting Inc., the Claims Processing Agent. A Questionnaire that is submitted by facsimile, telecopy or other electronic transmission will **not** be accepted and will **not** be deemed filed.

3. Questionnaires may be filed by mail, Federal Express or United Parcel Service, or by using a similar hand delivery service.

   - Use this address if using U.S. Mail:

     Rust Consulting, Inc.
     Claims Processing Agent
     Re: W.R. Grace & Co. Bankruptcy
     P.O. Box 1620
     Faribault, MN 55021

   - Use this address if delivering by Federal Express, United Parcel Service, or a similar hand delivery service:

     Rust Consulting, Inc.
     Claims Processing Agent
     Re: W.R. Grace & Co. Bankruptcy
     201 S. Lyndale Ave.
     Faribault, MN 55021

     (between the hours of 9:00 a.m. and 4:00 p.m., Eastern Time, on business days).

   Do **not** send any Questionnaire to the Debtors, counsel for the Debtors, the Official Committee of Unsecured Creditors, the Official Committee of Asbestos Personal Injury Claimants, the Official Committee of Asbestos Property Damage Claimants, the Official Committee of Equity Security Holders, or such Committees' counsel. Questionnaires that are filed with or sent to anyone other than Rust Consulting, Inc. will be deemed not to have been submitted, and such Questionnaires will not be considered.

4. Your completed Questionnaire must (i) be written in English, and (ii) attach relevant supporting materials as instructed further below.

5. ALL HOLDERS OF CLAIMS DESCRIBED ON PAGE i (AND AS DESCRIBED IN FURTHER DETAIL IN INSTRUCTION NO. 1) ARE REQUIRED TO FILE THIS QUESTIONNAIRE BY **[DATE]**. ANY SUCH HOLDER WHO FAILS TO DO SO **SHALL BE FOREVER BARRED, ESTOPPED AND ENJOINED** FROM ASSERTING ANY SUCH CLAIMS.

   YOUR QUESTIONNAIRE WILL BE USED IN CONNECTION WITH THE ESTIMATION HEARING TO BE CONDUCTED BY THE COURT PURSUANT TO THE ESTIMATION PROCEDURES ORDER (A COPY OF WHICH IS ATTACHED AS APPENDIX B).

6. ANY SUBSEQUENT AMENDMENT TO THE QUESTIONNAIRE WILL NOT BE CONSIDERED FOR ANY PURPOSE UNLESS RECEIVED BY **[DATE]**.

7. This Questionnaire must be filed on behalf of any deceased Claimant who would have held a claim described on page i of this Questionnaire.

B. PART I -- Identity of Injured Person and Legal Counsel

Respond to all applicable questions. If you are represented by a lawyer, then in Part I (b), please provide your lawyer's name and the name, telephone number and address of his/her firm. If you are represented by a lawyer, he/she must assist in the completion of this Questionnaire. Also, if you would prefer that the Debtors send any additional materials only to your lawyer, instead of sending such materials to you, then check the box indicating this in Part I (b).

If the injured person is deceased, then be sure to complete Part I (c), which concerns the primary and contributing causes of death.

All references to "you" or the like in Parts I through VII and IX shall mean the injured person.

C. PART II -- Asbestos-Related Medical Condition(s)

If you have received multiple diagnoses and/or consulted with multiple doctors, please complete a separate Part II to provide the requested information **for each diagnosis and/or doctor**. For your convenience, additional copies of Part II are attached as Appendix C to this Questionnaire. Please respond to all applicable questions. If a section is left blank, then that section will be interpreted to mean that the injured party does not have the specified injuries, conditions, or test results addressed in that section.

Respond to all applicable questions. If a section is left blank, then that section will be interpreted to mean that the injured party does not have the specified injuries, conditions, or test results addressed in that section. To complete questions related to injuries, medical diagnoses, and/or conditions, please use the following definitions:

Mesothelioma: Malignant mesothelioma, of which exposure to Grace asbestos-containing products had a substantial causal role in the development of the condition, diagnosed in separate opinions from two independent pathologists certified by the American Board of Pathology.

Asbestos-Related Lung Cancer 1: Primary lung cancer (1) diagnosed on the basis of findings by an independent pathologist certified by the American Board of Pathology; (2) with evidence of asbestosis based on a chest x-ray reading by a B-reader and replicated by an independent B-reader, both of whom are certified by the National Institute for Occupational Safety and Health, of at least 1/1 on the ILO grade scale, or asbestosis determined by pathology; and (3) with a supporting independent medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the lung cancer.

Asbestos-Related Lung Cancer 2: Primary lung cancer (1) diagnosed on the basis of findings by an independent pathologist certified by the American Board of Pathology; (2) with evidence of asbestos-related nonmalignant disease based on a chest x-ray reading by a B-reader and replicated by an independent B-reader, both of whom are certified by the National Institute for Occupational Safety and Health, of at least 1/0 on the ILO grade scale, or diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000); and (3) with a supporting independent medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the lung cancer.

Other Cancer: Primary colon, laryngeal, esophageal, pharyngeal or stomach cancer (1) diagnosed on the basis of findings by an independent pathologist certified by the American Board of Pathology; (2) with evidence of asbestosis based on a chest x-ray reading by a B-reader and replicated by an independent B-reader, both of whom are certified by the National Institute for Occupational Safety and Health, of at least 1/1 on the ILO grade scale, or asbestosis determined by pathology; and (3) with a supporting independent medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the lung cancer.

Clinically Severe Asbestosis: Asbestosis (1) diagnosed by an independent pulmonologist or internist certified by the American Board of Internal Medicine, (2) with either (a) a chest x-ray reading by a B-reader and replicated by an independent B-reader, both of whom are certified by the National Institute for Occupational Safety and Health, of at least 2/1 on the ILO grade scale, or (b) asbestosis determined by pathology; (3) with an independent pulmonary function test demonstrating either (a) total lung capacity less than 65% or (b) forced vital capacity less than 65% and a FEV1/FVC ratio greater than or equal to 65%; and (4) with a supporting independent medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the asbestosis.

Asbestosis: Asbestosis (1) diagnosed by an independent pulmonologist or internist certified by the American Board of Internal Medicine; (2) with either (a) a chest x-ray reading by a B-reader and replicated by an independent B-reader, both of whom are certified by the National Institute for Occupational Safety and Health, with one of the following: (i) at least 1/0 on the ILO grade scale, or (ii) diffuse pleural thickening as defined in the ILO's *Guidelines for the Use of the ILO International Classification of Radiographs and Pneumoconioses* (2000), or (b) asbestosis determined by pathology; (3) with an independent pulmonary function test demonstrating a FEVI/FVC ratio greater than or equal to 65% with either (a) total lung capacity less than 80% or (b) forced vital capacity less than 80%; and (4) with a supporting independent medical diagnosis and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the asbestosis.

Other Asbestos Disease: Any asbestos-related injuries, medical diagnoses, and/or conditions other than those above.

THESE ARE THE DEFINITIONS THAT GRACE WILL USE IN DETERMINING ITS OWN POSITION REGARDING ITS LIABILITY FOR ASBESTOS-RELATED PERSONAL INJURY AND WRONGFUL DEATH CLAIMS AS A WHOLE. ALL INFORMATION, TESTS, DIAGNOSES, AND DOCUMENTATION SHOULD CONFORM TO THE DEFINITIONS. INFORMATION, TESTS, DIAGNOSES, AND DOCUMENTATION THAT DO NOT CONFORM TO THE DEFINITIONS **MAY BE SUBMITTED**, BUT GRACE WILL ASSERT IN COURT THAT THEY SHOULD BE GIVEN **LITTLE OR NO WEIGHT AND THE CLAIM ESTIMATED AT ZERO VALUE.**

Supporting Documents for Diagnosis

This Questionnaire must be accompanied by any and all documents that you and your counsel have or reasonably can obtain that support or otherwise relate to your diagnosis and your exposure to asbestos-containing products as having a substantial causal role in the development of the medical diagnoses, and/or conditions claimed. Include a history of your exposure to Grace asbestos-containing products sufficient to establish a 10-year latency period, and include all documents that relate to your exposure to Grace asbestos-containing products.

Any diagnosis relied upon should be from a medical doctor with the qualifications described in this Questionnaire and who is independent of lawyers representing asbestos claimants. A doctor or B-reader is considered "independent" if the doctor or B-reader has no social or financial relationship (direct or indirect) with lawyers representing asbestos claimants.

X-rays and B-reads

If a chest x-ray reading by a certified B-reader is provided along with a replicated reading by an independent certified B-reader, the chest x-rays do not need to be attached at this time, but may be requested at a later time. **The Debtors intend to take the position that all chest x-ray readings must be replicated and comply with the standards set forth in the International Labour Organization's *2000 International Classification of Radiographs of Pneumoconioses*.**

Pulmonary Function Tests

All pulmonary function test results must include the actual raw data, including all spirometric tracings, on which the results are based. All examinations, tests, and diagnoses should conform to the instructions above and below. **The Debtors intend to take the position that all pulmonary function test results must comply with the standards set forth in the American Thoracic Society's *Lung Function Testing; Selection of Reference Values and Interpretive Strategies.***

Asbestosis

The injured person should include the following for all diagnoses of asbestosis:

i. a physical examination of the Claimant by the physician providing the diagnosis of the asbestos-related disease;

ii. X-ray readings by certified B-readers; and

iii. Pulmonary function test results.

Pathological evidence of the non-malignant asbestos disease in the case of a Claimant who was deceased at the time the Claim was filed shall suffice in lieu of (i), (ii), and (iii) above.

The Debtors will take the position that a physician's finding that an injured person's disease is "consistent with" or "compatible with" asbestosis is insufficient under applicable rules of evidence to prove asbestosis and will therefore seek to estimate the value of any claim based on such a diagnosis with no further evidence at zero and to value any such Claim at zero for purposes of allowance and distribution.

Other Asbestos Disease

Any person asserting an Other Asbestos Disease should include all chest x-ray readings, pulmonary function test results, and supporting medical diagnoses and supporting documentation establishing that exposure to Grace asbestos-containing products had a substantial causal role in the development of the disease.

D. PART III -- Exposure to Asbestos-Containing Products

In Part III (a), please provide the requested information for the job and worksite at which you were exposed to Grace asbestos-containing products. Indicate the dates of exposure to each Grace asbestos-containing product. If your exposure was a result of your employment, use the list of occupation and industry codes below to indicate your occupation and the industry in which you worked at each site. If you worked at more than one job and/or worksite from which you claim exposure to Grace asbestos-containing products, please use additional copies of Part III (a), and supply the occupational code, industry code, and period of exposure for each applicable job/worksite combination. Use a separate copy of the form for each job/worksite combination. For your convenience, additional copies of Part III are attached as Appendix D to this Questionnaire.

Occupation Codes

01. Air conditioning and heating installer/maintenance
02. Asbestos miner
03. Asbestos plant worker/asbestos manufacturing worker
04. Asbestos removal/abatement
05. Asbestos sprayer/spray gun mechanic
06. Assembly line/factory/plant worker
07. Auto mechanic/bodywork/brake repairman
08. Boilermaker
09. Boiler repairman
10. Boiler worker/cleaner/inspector/engineer/installer
11. Building maintenance/building superintendent
12. Brake manufacturer/installer
13. Brick mason/layer/hod carrier
14. Burner operator
15. Carpenter/woodworker/cabinetmaker
16. Chipper
17. Clerical/office worker
18. Construction - general
19. Custodian/janitor in office/residential building
20. Custodian/janitor in plant/manufacturing facility
21. Electrician/inspector/worker
22. Engineer
23. Firefighter
24. Fireman
25. Flooring installer/tile installer/tile mechanic
26. Foundry worker
27. Furnace worker/repairman/installer
28. Glass worker
29. Heavy equipment operator (includes truck, forklift, & crane)
30. Insulator
31. Iron worker
32. Joiner
33. Laborer
34. Longshoreman
35. Machinist/machine operator
36. Millwright/mill worker
37. Mixer/bagger
38. Non-asbestos miner
39. Painter
40. Pipefitter
41. Plasterer
42. Plumber - install/repair
43. Power plant operator
44. Professional (*e.g.*, accountant, architect, physician)
45. Railroad worker/carman/brakeman/machinist/conductor
46. Refinery worker
47. Remover/installer of gaskets
48. Rigger/stevedore/seaman
49. Rubber/tire worker
50. Sandblaster
51. Sheet metal worker/sheet metal mechanic
52. Shipfitter/shipwright/ship builder
53. Shipyard worker (md. repair, maintenance)
54. Steamfitter
55. Steelworker
56. Warehouse worker
57. Welder/blacksmith
58. Other

Industry Codes

001. Asbestos abatement/removal
002. Aerospace/aviation
100. Asbestos mining
101. Automotive
102. Chemical
103. Construction trades
104. Iron/steel
105. Longshore
106. Maritime
107. Military (other than U.S. Navy)
108. Non-asbestos products manufacturing
109. Petrochemical
110. Railroad
111. Shipyard-construction/repair
112. Textile
113. Tire/rubber
114, U.S. Navy
115. Utilities
116. Grace asbestos manufacture or milling
117. Non-Grace asbestos manufacture or milling
118. Other

In Part III (b), please provide the requested information for the each site at which the you were exposed to asbestos-containing products other than Grace products. Indicate the dates of exposure to non-Grace asbestos-containing products. If exposure was in connection with your employment, use the list of occupation and industry codes in Part III (a) to indicate your occupation and the industry in which you worked at each site. If you worked at more than one job and/or worksite where you claim exposure to asbestos, please use additional copies of Part III (b) and supply the occupational code, industry code and period of exposure for each applicable job/worksite combination.

E. PART IV -- Employment History

In Part IV, please provide the information requested for each job you have held, other than jobs already listed in Part III. Use the list of occupation and industry codes in the instructions to Part III to indicate your occupation and the industry in which you worked for each job.

F. PART V -- Litigation and Claims Regarding Asbestos and/or Silica

In Part V, please describe any lawsuits and/or claims that were filed by you or on your behalf regarding asbestos or silica.

G. PART VI -- Claims by Dependents or Related Persons

Part VI is to be completed only by dependents or related persons (such as spouse or child) of an injured person who sued the Debtors before April 2, 2001 for an asbestos-related personal injury or wrongful death claim against Grace not involving physical injury to him-/herself on account of his/her own exposure. One example of such a claim would be a claim for loss of consortium. If you are asserting such a claim, complete the entire Questionnaire, providing all information and documentation regarding the injured person.

H. PART VII -- Supporting Documentation

This Questionnaire must be accompanied by any and all documents that you and your counsel have or reasonably can obtain that support or otherwise relate to your diagnosis and your exposure to asbestos-containing products as having a substantial causal role in the development of the medical diagnoses, and/or conditions claimed.

Original documents that are attached will be returned within a reasonable time after Grace, its professionals, and its experts have reviewed the documents. In Part VII, please mark the boxes next to each type of documents that you are submitting with this Questionnaire.

I. PART VIII -- Attestation of Injured Person that Information is True and Complete

By signing Part VIII, you, the injured person, are attesting and swearing, under penalty of perjury, that, to the best of your knowledge, all of the information in this Questionnaire is true and accurate. You are further attesting and swearing that you have not omitted any requested information, the inclusion of which would have a material effect on any right to assert a Claim against the Debtors' estates. If the injured person is deceased, then the executor of the person's will (or similar estate representative) must complete this Questionnaire, including Part X, and references in Part X to "you" mean the person completing and filing this Questionnaire.

J. PART IX -- To be Completed by the Legal Representative of the Injured Person

If you are represented by a lawyer, your lawyer must complete and sign Part IX. Your lawyer must assist in the completion of this Questionnaire and must conduct reasonable inquiries and investigation to obtain all materials requested by this Questionnaire. By signing Part IX, your lawyer is attesting and swearing that to the best of his/her knowledge, based upon a reasonable investigation of the facts, all of the information in this Questionnaire is true, accurate and complete.

PART I: IDENTITY OF INJURED PERSON AND LEGAL COUNSEL

a. GENERAL INFORMATION

1. **Name of Claimant:** _____ **2. Gender:** ☐ Male ☐ Female
3. **Race (for purposes of evaluating Pulmonary Function Test results):** ☐ White/Caucasian ☐ African American ☐ Other
4. **Social Security Number:** _____ **5. Birth Date:** _____
6. **Mailing Address:** _____
   Address City State/Province Zip/Postal Code
7. **Daytime Telephone number:** _____

b. LAWYER'S NAME AND FIRM

1. **Name of Lawyer:** _____
2. **Name of Law Firm With Which Lawyer is Affiliated:** _____
3. **Mailing Address of Firm:** _____
   Address City State/Province Zip/Postal Code
4. **Law firm's telephone number or attorney's direct line:** _____

☐ Check this box if you would like the Debtors to send subsequent material relating to your claim to your lawyer, in lieu of sending such materials to you.

c. CAUSE OF DEATH (IF APPLICABLE)

1. **Is the injured person living or deceased?** ☐ Living ☐ Deceased **If deceased, date of death:** _____
2. **If the injured person is deceased, then attach a copy of the death certification to this Questionnaire and complete the following:**

   Primary Cause of Death (as stated in the Death Certificate): _____

   Contributing Cause of Death (as stated in the Death Certificate): _____

PART II: ASBESTOS-RELATED CONDITION(S)

a. DIAGNOSED CONDITION(S)

Mark the box next to the conditions with which you have been diagnosed and provide all information required in the instructions to this Questionnaire. Also, attach medical records that comply with the requirements set forth in the Instructions to Part II. If you have been diagnosed with multiple conditions and/or if you received diagnoses, tests, consultations, treatments, or medical assessments relating to the same condition by multiple doctors, please complete a separate Part II for each such diagnosis, test, consultation, treatment, or medical assessment. For your convenience, additional copies of Part II are attached as Appendix C to this Questionnaire.

1. **Please check the box next to the condition being alleged:**

☐ Asbestos-Related Lung Cancer	☐ Mesothelioma
☐ Asbestosis	☐ Other Cancer (cancer not related to lung cancer)
☐ Other Asbestos Disease	☐ Clinically Severe Asbestosis

2. **Information Regarding Diagnosis**

   Date of Diagnosis: _____

   Diagnosing Doctor's Name: _____ **Diagnosing Doctor's Specialty:** _____

   Diagnosing Doctor's Mailing Address: _____
   Address City State/Province Zip/Postal Code

   Diagnosing Doctor's Daytime Telephone Number: _____

With respect to your relationship to the diagnosing doctor, check all applicable boxes:

Was the diagnosing doctor your personal physician? ☐Yes ☐No

Did you pay for the services performed by the diagnosing doctor? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the diagnosing doctor? ☐Yes ☐No

Was the diagnosing doctor referred to you by counsel? ☐Yes ☐No

Did the doctor have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the diagnosing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the diagnosis? ☐ Yes ☐ No

Was the diagnosing doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis? ☐Yes ☐No

Was the diagnosing doctor provided with your complete occupational, medical and smoking history prior to diagnosis? ☐Yes ☐No

Do you currently use tobacco products? ☐ Yes ☐ No Have you ever used tobacco products? ☐ Yes ☐ No

If answer to either question is yes, please indicate whether you have regularly used any of the following tobacco products and the dates and frequency with which such products were used:

☐ **Cigarettes** **Packs Per Day (half pack = .5) _____ Start Date Year _____ End Year _____**

☐ **Cigars** **Cigars Per Day _____ Start Year _____ End Year _____**

☐ **If Other Tobacco Products, please specify (e.g., chewing tobacco):_____ Amount Per Day _____ Start Year (year) _____ End Year _____**

Have you ever been diagnosed with chronic obstructive pulmonary disease ("COPD")? ☐ Yes ☐ No

If yes, please attach all documents regarding such diagnosis and explain the nature of the diagnosis: _____

_____

_____

3. **Information Regarding Chest X-Ray**

Please check the box next to the applicable location where your chest x-ray was taken (check one):

☐ Mobile laboratory ☐ Job site ☐ Union Hall ☐ Doctor office ☐ Hospital ☐ Other: _____

Address where chest x-ray taken: _____

4. **Information Regarding Chest X-Ray Reading**

Date of Reading: _____ **ILO score:** _____

Name of B-Reader: _____ **B-Reader's Daytime Telephone Number:** _____

B-Reader's Mailing Address: _____

Address City State/Province Zip/Postal Code

With respect to your relationship to the b-reader, check all applicable boxes:

Did you pay for the services performed by the reader? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the reader? ☐Yes ☐No

Was the reader referred to you by counsel? ☐Yes ☐No

Did the reader have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the reader certified by the National Institute of Occupational Safety and Health at the time of the reading? ☐ Yes ☐ No

5. **Information Regarding Pulmonary Function Test:**

Date of Test: _____ **Total Lung Capacity (TLC): ___% of predicted**

List your height in feet and inches when test given:_____ **Forced Vital Capacity (FVC): ____% of predicted**

List your weight in pounds when test given:_____ **FEV1/FVC Ratio: ____% of predicted**

Name of Doctor Performing Test (if applicable): _____ **Doctor's Specialty:** _____

Name of Clinician Performing Test (if applicable): _____

Testing Doctor or Clinician's Mailing Address: _____

Address City State/Province Zip/Postal Code

Testing Doctor or Clinician's Daytime Telephone Number: _____

Name of Doctor Interpreting Test: _____ **Doctor's Specialty:** _____

Interpreting Doctor's Mailing Address: _____

Interpreting Doctor's Daytime Telephone Number: _____

With respect to your relationship to the doctor or clinician who performed the pulmonary function test check all applicable boxes:

If the test was performed by a doctor, was the doctor your personal physician? ☐Yes ☐No

Did you or your insurance company pay for the services performed by the testing doctor and/or clinician? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the testing doctor or clinician? ☐Yes ☐No

Was the testing doctor or clinician referred to you by counsel? ☐Yes ☐No

Did the doctor or clinician have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the testing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the pulmonary function test? ☐ Yes ☐ No

With respect to your relationship to the doctor interpreting the results of the pulmonary function test check all applicable boxes:

Was the doctor your personal physician? ☐Yes ☐No

Did you or your insurance company pay for the services performed by the doctor? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the doctor? ☐Yes ☐No

Was the doctor referred to you by counsel? ☐Yes ☐No

Did the doctor have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the doctor interpreting the pulmonary function test results certified as a pulmonologist or internist by the American Board of Internal Medicine at the time the test results were reviewed? ☐ Yes ☐ No

6. **Information Regarding Pathology Reports:**

Date of Pathology Report: _____ **Findings:** _____

Name of Doctor Issuing Report: _____ **Doctor's Specialty:** _____

Doctor's Mailing Address: _____
Address City State/Province Zip/Postal Code

Doctor's Daytime Telephone Number: _____

With respect to your relationship to the doctor, check all applicable boxes:

Was the doctor your personal physician? ☐Yes ☐No

Did you or your insurance company pay the doctor for the services performed? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the doctor? ☐Yes ☐No

Was the doctor referred to you by counsel? ☐Yes ☐No

Did the doctor have a financial or social relationship with your legal counsel? ☐Yes ☐ No

Was the doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis? ☐ Yes ☐ No

7. **If alleging Other Cancer, please mark the box(es) next to the applicable primary cancer(s) being alleged:**

☐ colon ☐ pharyngeal ☐ esophageal ☐ laryngeal ☐ stomach cancer ☐ other, please specify _____

8. **If alleging Other Asbestos Diseases, please describe the diagnosis:** _____

_____

9. **Have you received medical treatment from a doctor for the condition alleged?** ☐ Yes ☐ No

If yes, please complete the following:

Name of Treating Doctor: _____ **Treating Doctor's Specialty:** _____

Treating Doctor's Mailing Address: _____
Address City State/Province Zip/Postal Code

Treating Doctor's Daytime Telephone number: _____

Were you required to retain counsel in order to receive any of the services performed by the doctor? ☐ Yes ☐ No

PART III: EXPOSURE TO ASBESTOS-CONTAINING PRODUCTS

If you were exposed at more than one site where you claim exposure to asbestos-containing products, then complete a separate Part III for each applicable site. For your convenience, additional copies of Part III are attached as Appendix D to this Questionnaire.

a. EXPOSURE TO GRACE ASBESTOS-CONTAINING PRODUCTS

1. Site of Exposure:

Site Type: ☐ Residence ☐ Business

Name of Site: _____ **Site Owner:** _____

Location: _____
Address City State/Province Zip/Postal Code

2. Employer During Exposure: _____

3. Please include any unions of which you were a member during your employment: _____

4. List all Grace asbestos-containing products to which you claim exposure at the particular site. If additional space is needed, please use the additional copies of Part III in Appendix D to this Questionnaire to complete a separate Part III (a)(4) as needed.

a. Products Attributed to Grace (Include type of product and product name): _____

_____

b. Basis for Identification of each Grace Product: _____

_____

c. Dates and Frequency (hours/day, days/year) of Exposure to each Product Attributed to Grace: _____

_____

d. If you were exposed as a result of your employment, please indicate the occupation and industry during exposure to each product (see instructions for occupation and industry codes):

Occupation Code:____. If Code 58, specify _____ **Industry Code:** ____. If Code 118, specify _____

e. Is your exposure a result of working in or around areas where Grace asbestos-containing products were being installed, mixed, removed or cut by others? ☐ Yes ☐ No

If yes, please indicate your regular proximity to such areas: ☐ 1-5 ft. ☐ 6-15 ft. ☐ 16-30 ft. ☐ 31-50 ft. ☐ 51-100 ft. ☐ 100+ ft.

f. During exposure to each Grace asbestos-containing product which, if any, of the following were you? (check all that apply)

☐ A worker who personally mixed Grace asbestos-containing products

☐ A worker who personally removed or cut Grace asbestos-containing products

☐ A worker who personally installed Grace asbestos-containing products

☐ A worker at the site where Grace asbestos-containing products were being installed, mixed, removed or cut by others

☐ A worker in the work space where Grace asbestos-containing products were being installed, mixed, removed or cut by others

☐ If Other, please specify: _____

5. Are you asserting an injury caused by exposure to Grace asbestos-containing products through contact/proximity with another injured person? ☐ **Yes** ☐ **No**

If yes, complete questions 6 through 14 of this section. If no, please skip to Part III(b)

6. Please indicate the following information regarding the other injured person:

Name of Other Injured Person: _____

Gender: ☐ Male ☐ Female **Social Security Number:** _____ **Birth Date:** _____

7. **What is your Relationship to Other Injured Person?** ☐ Spouse ☐ Child ☐ Other

8. **Nature of Other Injured Person's Exposure to <u>each</u> Grace Asbestos-Containing Products:** _____

_____

9. **Dates Other Injured Person was Exposed to <u>each</u> Grace Asbestos-Containing Products: From:** _____ **To:** _____

10. **Other Injured Person's Basis for Identification of <u>each</u> Asbestos-Containing Product as Grace Product:** _____

_____

11. **Has the Other Injured Person filed a lawsuit related to his/her exposure?** ☐ **Yes** ☐ **No**

If yes, please provide caption, case number, file date, and court name for the lawsuit:

Caption: _____

Case Number: _____ **File Date:** _____

Court Name: _____

12. **Nature of Your Own Exposure to Grace Asbestos-Containing Product:** _____

_____

13. **Dates of Your Own Exposure to Grace Asbestos-Containing Product: From:** _____ **To:** _____

14. **Your Basis for Identification of Asbestos-Containing Product as Grace Product:** _____

_____

b. EXPOSURE TO OTHER ASBESTOS-CONTAINING PRODUCTS

1. **Site of Exposure:**

Site Type: ☐ Residence ☐ Business

Name of Site: _____ **Site Owner:** _____

Location: _____
Address City State/Province Zip/Postal Code

2. **Dates of Exposure to Non-Grace Asbestos-Containing Products:** From _____ To _____

3. **List all Non-Grace asbestos-containing products to which you claim exposure at the particular site. If additional space is needed, please use the additional copies of Part III in Appendix D to this Questionnaire to complete a separate Part III (b)(3) as needed.**

a. **Asbestos Containing Products Not Attributed to Grace (Include type of product and product name):** _____

_____

b. **Basis for Identification of <u>each</u> Non-Grace Asbestos Product:** _____

_____

c. **Dates and Frequency (hours/day, days/year) of Exposure to <u>each</u> Product Not Attributed to Grace:** _____

_____

d. **If you were exposed as a result of your employment, please indicate the occupation and industry during exposure to <u>each</u> product (see instructions for occupation and industry codes):**

Occupation Code:____. If Code 58, specify _____ **Industry Code:** ____. If Code 117, specify _____

e. **Is your exposure a result of working in or around areas where non-Grace asbestos-containing products were being installed, mixed, removed or cut by others?** ☐Yes ☐No

If yes, please indicate your regular proximity to such areas: ☐ 1-5 ft. ☐ 6-15 ft. ☐ 16-30 ft. ☐ 31-50 ft. ☐ 51-100 ft. ☐ 100+ ft.

f. **During exposure to each non-Grace asbestos-containing products which, if any, of the following were you? (check all that apply)**

- ☐ A worker who personally mixed Non-Grace asbestos-containing products
- ☐ A worker who personally removed or cut Non-Grace asbestos-containing products
- ☐ A worker who personally installed Non-Grace asbestos-containing products
- ☐ A worker at the site where Non-Grace asbestos-containing products were being installed, mixed, removed or cut by others
- ☐ A worker in the work space where Non-Grace asbestos-containing products were being installed, mixed, removed or cut by others
- ☐ If Other, please specify: ____________________

PART IV: EMPLOYMENT HISTORY

Other than jobs listed in Part III, please complete a separate Part IV for all of your prior work experience up to and including your current employment. For each job, include your employer, location of employment, and dates of employment. Only include jobs at which you worked for at least one month.

Occupation Code: ____. If Code 58, specify ____________ **Industry Code:** ____. If Code 118, specify ____________

Employer: ____________________ **Beginning of Employment** ________ **End of Employment** ________

Location: ____

Address City State/Province Zip/Postal Code

Occupation Code: ____. If Code 58, specify ____________ **Industry Code:** ____. If Code 118, specify ____________

Employer: ____________________ **Beginning of Employment** ________ **End of Employment** ________

Location: ____

Address City State/Province Zip/Postal Code

Occupation Code: ____. If Code 58, specify ____________ **Industry Code:** ____. If Code 118, specify ____________

Employer: ____________________ **Beginning of Employment** ________ **End of Employment** ________

Location: ____

Address City State/Province Zip/Postal Code

PART V: LITIGATION AND CLAIMS REGARDING ASBESTOS AND/OR SILICA

a. LITIGATION

1. **Have you ever been a plaintiff in a lawsuit regarding asbestos or silica?** ☐ Yes ☐ No

   If yes, please complete the rest of this Part V(a) for each lawsuit. For your convenience, additional copies of Part V are attached as Appendix E to this Questionnaire

2. **Please provide the caption, case number, file date, and court name for the lawsuit you filed**

   Caption: ____

   Case Number: ____________________ **File Date:** ____________________

   Court Name: ____

3. **Was Grace a defendant in the lawsuit?** ☐ Yes ☐ No

4. **Was the lawsuit dismissed?** ☐ Yes ☐ No

   If yes, please provide the basis for dismissal of the lawsuit? ____________________

   ____

   ____

5. **Has a judgment or verdict been entered?** ☐ Yes ☐ No

   If yes, please indicate verdict amount and defendant(s): _____

   _____

   _____

6. **Was a settlement agreement reached in this lawsuit?** ☐ Yes ☐ No

   If yes, please (a) indicate the settlement amount and (b) describe the terms of the settlement and the applicable defendants:

   a. **Settlement Amount:** _____

   b. **Terms of the settlement (including any payments) and the applicable defendants:** _____

   _____

7. **Were you deposed in this lawsuit?** ☐ Yes ☐ No

   If yes, please attach a copy of your deposition to this Questionnaire.

b. CLAIMS

1. **Have you ever asserted a claim regarding asbestos and/or silica, including but not limited to a claim against an asbestos trust (other than a formal lawsuit in court)?** ☐ Yes ☐ No

   If yes, please complete the rest of this Part V(b). If no, please skip to Part VI.

2. **Date the claim was submitted:** _____

3. **Person or entity against whom the claim was submitted:** _____

4. **Description of claim:** _____

   _____

   _____

5. **Was claim settled?** ☐ Yes ☐ No

6. **Please indicate settlement amount:** _____

7. **Was the claim dismissed or otherwise disallowed or not honored?** ☐ Yes ☐ No

   If yes, provide the basis for dismissal of the claim: _____

   _____

PART VI: CLAIMS BY DEPENDENTS OR RELATED PERSONS

Name of Dependent or Related Person: _____ **Gender:** ☐ Male ☐ Female

Social Security Number: _____ **Birth Date:** _____

Mailing Address: _____

Address City State/Province Zip/Postal Code

Daytime Telephone number: _____

Financially Dependent: ☐ Yes ☐ No

Relationship to Injured Party: ☐ Spouse ☐ Child ☐ Other If other, please specify _____

PART VII: SUPPORTING DOCUMENTATION

1. Please use the checklist below to indicate which documents you are submitting with this form.

- ☐ Medical records and/or report containing a diagnosis
- ☐ Lung function test results/interpretations
- ☐ Pathology reports
- ☐ Supporting documentation of exposure to Grace asbestos-containing products
- ☐ Supporting documentation of other asbestos exposure
- ☐ X-rays and reports/interpretations
- ☐ CT scans and any reports/interpretations
- ☐ Depositions from lawsuits indicated in Part V of this Questionnaire
- ☐ Death Certification

2. Please sign the authorization attached as Appendix F to this Questionnaire permitting the disclosure of medical records and medical expenses (this release includes both doctors and hospitals).

☐ The executed release is attached

PART VIII: ATTESTATION OF INJURED PERSON THAT INFORMATION IS TRUE AND COMPLETE

The information provided in this Questionnaire must be accurate and truthful. This Questionnaire is an official court document that may be used as evidence in any legal proceeding regarding your Claim. The penalty for presenting a fraudulent Questionnaire is a fine of up to $500,000 or imprisonment for up to five years, or both. 18 U.S.C. §§ 152 & 3571.

TO BE COMPLETED BY THE INJURED PERSON.

I swear, **under penalty of perjury**, that, to the best of my knowledge, all of the foregoing information contained in this Questionnaire is true and accurate. I further swear that I have not omitted any requested information, the inclusion of which, would have a material effect on my right to a Claim against the Debtors' estates.

Signature: _____ Date: _____

Please Print Name: _____

PART IX: TO BE COMPLETED BY THE LEGAL REPRESENTATIVE OF THE INJURED PERSON

a. SOCIAL AND FINANCIAL RELATIONSHIPS

Is there, or has there ever been, any social or financial relationship (direct or indirect) between you and/or your firm (or any other firm representing Claimants) and any of the doctors listed by the claimant in Part II of this Questionnaire? ☐ **Yes** ☐ **No**

If yes, please indicate which doctors and the nature of the relationship with each: _____

_____

_____

b. ATTESTATION THAT INFORMATION IS TRUE AND COMPLETE

The information provided in this Questionnaire must be accurate and truthful. This Questionnaire is an official court document that may be used as evidence in any legal proceeding regarding your Claim. The penalty for presenting a fraudulent Questionnaire is a fine of up to $500,000 or imprisonment for up to five years, or both. 18 U.S.C. §§ 152 & 3571.

TO BE COMPLETED BY THE LEGAL REPRESENTATIVE OF THE INJURED PERSON.

I swear that, to the best of my knowledge, all of the information contained in this Questionnaire is true and accurate. I further swear that I have not omitted any requested information, the inclusion of which, would have a material effect on the injured person's right to a Claim against the Debtors' estates.

Signature: _____ Date: _____

Please Print Name: _____

APPENDIX A
List of Debtors

W. R. Grace & Co. (f/k/a Grace Specialty Chemicals, Inc.)
W. R. Grace & Co. Conn., A-1 Bit & Tool Co., Inc.
Alewife Boston Ltd.
Alewife Land Corporation
Amicon, Inc.
CB Biomedical, Inc. (f/k/a Circe Biomedical, Inc.)
CCHP, Inc.
Coalgrace, Inc.
Coalgrace II, Inc.
Creative Food 'N Fun Company
Darex Puerto Rico, Inc.
Del Taco Restaurants, Inc.
Dewey and Almy, LLC (f/k/a Dewey and Almy Company)
Ecarg, Inc.
Five Alewife Boston Ltd.
GC Limited Partners I, Inc. (f/k/a Grace Cocoa Limited Partners I, Inc.)
GC Management, Inc. (f/k/a Grace Cocoa Management, Inc.)
GEC Management Corporation
GN Holdings, Inc.
GPC Thomasville Corp.
Gloucester New Communities Company, Inc.
Grace A-B Inc.
Grace A-B II Inc.
Grace Chemical Company of Cuba
Grace Culinary Systems, Inc.
Grace Drilling Company
Grace Energy Corporation
Grace Environmental, Inc.
Grace Europe, Inc.
Grace H-G Inc.
Grace H-G II Inc.
Grace Hotel Services Corporation
Grace International Holdings, Inc. (f/k/a Dearborn International Holdings, Inc.)
Grace Offshore Company
Grace PAR Corporation
Grace Petroleum Libya Incorporated
Grace Tarpon Investors, Inc.
Grace Ventures Corp.
Grace Washington, Inc.
W. R. Grace Capital Corporation.
W. R. Grace Land Corporation
Gracoal, Inc.
Gracoal II, Inc.
Guanica-Caribe Land Development Corporation
Hanover Square Corporation
Homco International, Inc.
Kootenai Development Company
L B Realty, Inc.
Litigation Management, Inc. (f/k/a GHSC Holding, Inc., Grace JVH, Inc., Asbestos Management, Inc.)
Monolith Enterprises, Incorporated
Monroe Street, Inc.
MRA Holdings Corp. (f/k/a Nestor-BNA Holdings Corporation)
MRA Intermedco, Inc. (f/k/a Nestor-BNA, Inc.)
MRA Staffing Systems, Inc. (f/k/a British Nursing Association, Inc.)
Remedium Group, Inc. (f/k/a Environmental Liability Management, Inc., E&C Liquidating Corp., Emerson & Cuming, Inc.)
Southern Oil, Resin & Fiberglass, Inc.
Water Street Corporation
Axial Basin Ranch Company
CC Partners (f/k/a Cross Country Staffing)
Hayden-Gulch West Coal Company, H-G Coal Company.

APPENDIX B

Estimation Procedures Order

APPENDIX C

Additional Copies of Part II of the Questionnaire

PART II: ASBESTOS-RELATED CONDITION(S)

a. DIAGNOSED CONDITION(S)

Mark the box next to the conditions with which you have been diagnosed and provide all information required in the instructions to this Questionnaire. Also, attach medical records that comply with the requirements set forth in the Instructions to Part II. If you have been diagnosed with multiple conditions and/or if you received diagnoses, tests, consultations, treatments, or medical assessments relating to the same condition by multiple doctors, please complete a separate Part II for each such diagnosis, test, consultation, treatment, or medical assessment.

1. Please check the box next to the condition being alleged:

☐ Asbestos-Related Lung Cancer
☐ Asbestosis
☐ Other Asbestos Disease
☐ Mesothelioma
☐ Other Cancer (cancer not related to lung cancer)
☐ Clinically Severe Asbestosis

2. Information Regarding Diagnosis

Date of Diagnosis: _____

Diagnosing Doctor's Name: _____ **Diagnosing Doctor's Specialty:** _____

Diagnosing Doctor's Mailing Address: _____
Address City State/Province Zip/Postal Code

Diagnosing Doctor's Daytime Telephone Number: _____

With respect to your relationship to the diagnosing doctor, check all applicable boxes:

Was the diagnosing doctor your personal physician? ☐Yes ☐No

Did you pay for the services performed by the diagnosing doctor? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the diagnosing doctor? ☐Yes ☐No

Was the diagnosing doctor referred to you by counsel? ☐Yes ☐No

Did the doctor have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the diagnosing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the diagnosis? ☐ Yes ☐ No

Was the diagnosing doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis? ☐Yes ☐No

Was the diagnosing doctor provided with your complete occupational, medical and smoking history prior to diagnosis? ☐Yes ☐No

Do you currently use tobacco products? ☐ Yes ☐ No Have you ever used tobacco products? ☐ Yes ☐ No

If answer to either question is yes, please indicate whether you have regularly used any of the following tobacco products and the dates and frequency with which such products were used:

☐ **Cigarettes** **Packs Per Day (half pack = .5)** _____ **Start Date Year** _____ **End Year** _____

☐ **Cigars** **Cigars Per Day** _____ **Start Year** _____ **End Year** _____

☐ **If Other Tobacco Products, please specify (e.g., chewing tobacco):**_____ **Amount Per Day** _____ **Start Year (year)** _____ **End Year** _____

Have you ever been diagnosed with chronic obstructive pulmonary disease ("COPD")? ☐ Yes ☐ No

If yes, please attach all documents regarding such diagnosis and explain the nature of the diagnosis:_____

_____

_____

3. Information Regarding Chest X-Ray

Please check the box next to the applicable location where your chest x-ray was taken (check one):

☐ Mobile laboratory ☐ Job site ☐ Union Hall ☐ Doctor office ☐ Hospital ☐ Other: _____

Address where chest x-ray taken: _____

4. Information Regarding Chest X-Ray Reading

Date of Reading: _____ **ILO score:** _____

Name of B-Reader: _____ **B-Reader's Daytime Telephone Number:** _____

B-Reader's Mailing Address: _____
Address City State/Province Zip/Postal Code

With respect to your relationship to the b-reader, check all applicable boxes:

Did you pay for the services performed by the reader? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the reader? ☐Yes ☐No

Was the reader referred to you by counsel? ☐Yes ☐No

Did the reader have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the reader certified by the National Institute of Occupational Safety and Health at the time of the reading? ☐ Yes ☐ No

5. Information Regarding Pulmonary Function Test:

Date of Test: _____ **Total Lung Capacity (TLC): ___% of predicted**

List your height in feet and inches when test given:_____ **Forced Vital Capacity (FVC): ____% of predicted**

List your weight in pounds when test given:_____ **FEV1/FVC Ratio: ____% of predicted**

Name of Doctor Performing Test (if applicable): _____ **Doctor's Specialty:** _____

Name of Clinician Performing Test (if applicable): _____

Testing Doctor or Clinician's Mailing Address: _____
Address City State/Province Zip/Postal Code

Testing Doctor or Clinician's Daytime Telephone Number: _____

Name of Doctor Interpreting Test: _____ **Doctor's Specialty:** _____

Interpreting Doctor's Mailing Address: _____

Interpreting Doctor's Daytime Telephone Number: _____

With respect to your relationship to the doctor or clinician who performed the pulmonary function test check all applicable boxes:

If the test was performed by a doctor, was the doctor your personal physician? ☐Yes ☐No

Did you or your insurance company pay for the services performed by the testing doctor and/or clinician? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the testing doctor or clinician? ☐Yes ☐No

Was the testing doctor or clinician referred to you by counsel? ☐Yes ☐No

Did the doctor or clinician have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the testing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the pulmonary function test? ☐ Yes ☐ No

With respect to your relationship to the doctor interpreting the results of the pulmonary function test check all applicable boxes:

Was the doctor your personal physician? ☐Yes ☐No

Did you or your insurance company pay for the services performed by the doctor? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the doctor? ☐Yes ☐No

Was the doctor referred to you by counsel? ☐Yes ☐No

Did the doctor have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the doctor interpreting the pulmonary function test results certified as a pulmonologist or internist by the American Board of Internal Medicine at the time the test results were reviewed? ☐ **Yes** ☐ **No**

6. Information Regarding Pathology Reports:

Date of Pathology Report: _____ **Findings:** _____

Name of Doctor Issuing Report: _____ **Doctor's Specialty:** _____

Doctor's Mailing Address: _____
Address City State/Province Zip/Postal Code

Doctor's Daytime Telephone Number: _____

With respect to your relationship to the doctor, check all applicable boxes:

Was the doctor your personal physician? ☐Yes ☐No

Did you or your insurance company pay the doctor for the services performed? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the doctor? ☐Yes ☐No

Was the doctor referred to you by counsel? ☐Yes ☐No

Did the doctor have a financial or social relationship with your legal counsel? ☐Yes ☐ No

Was the doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis? ☐ **Yes** ☐ **No**

7. If alleging Other Cancer, please mark the box(es) next to the applicable primary cancer(s) being alleged:

☐ colon ☐ pharyngeal ☐ esophageal ☐ laryngeal ☐ stomach cancer ☐ other, please specify _____

8. If alleging Other Asbestos Diseases, please describe the diagnosis: _____

_____

9. Have you received medical treatment from a doctor for the condition alleged? ☐ Yes ☐ No

If yes, please complete the following:

Name of Treating Doctor: _____ **Treating Doctor's Specialty:** _____

Treating Doctor's Mailing Address: _____
Address City State/Province Zip/Postal Code

Treating Doctor's Daytime Telephone number: _____

Were you required to retain counsel in order to receive any of the services performed by the doctor? ☐**Yes** ☐**No**

PART II: ASBESTOS-RELATED CONDITION(S)

a. DIAGNOSED CONDITION(S)

Mark the box next to the conditions with which you have been diagnosed and provide all information required in the instructions to this Questionnaire. Also, attach medical records that comply with the requirements set forth in the Instructions to Part II. If you have been diagnosed with multiple conditions and/or if you received diagnoses, tests, consultations, treatments, or medical assessments relating to the same condition by multiple doctors, please complete a separate Part II for each such diagnosis, test, consultation, treatment, or medical assessment.

1. Please check the box next to the condition being alleged:

☐ Asbestos-Related Lung Cancer
☐ Asbestosis
☐ Other Asbestos Disease
☐ Mesothelioma
☐ Other Cancer (cancer not related to lung cancer)
☐ Clinically Severe Asbestosis

2. Information Regarding Diagnosis

Date of Diagnosis: _____

Diagnosing Doctor's Name: _____ **Diagnosing Doctor's Specialty:** _____

Diagnosing Doctor's Mailing Address: _____
Address City State/Province Zip/Postal Code

Diagnosing Doctor's Daytime Telephone Number: _____

With respect to your relationship to the diagnosing doctor, check all applicable boxes:

Was the diagnosing doctor your personal physician? ☐Yes ☐No

Did you pay for the services performed by the diagnosing doctor? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the diagnosing doctor? ☐Yes ☐No

Was the diagnosing doctor referred to you by counsel? ☐Yes ☐No

Did the doctor have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the diagnosing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the diagnosis? ☐ Yes ☐ No

Was the diagnosing doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis? ☐Yes ☐No

Was the diagnosing doctor provided with your complete occupational, medical and smoking history prior to diagnosis? ☐Yes ☐No

Do you currently use tobacco products? ☐ Yes ☐ No Have you ever used tobacco products? ☐ Yes ☐ No

If answer to either question is yes, please indicate whether you have regularly used any of the following tobacco products and the dates and frequency with which such products were used:

☐ Cigarettes Packs Per Day (half pack = .5) _____ Start Date Year _____ End Year _____

☐ Cigars Cigars Per Day _____ Start Year _____ End Year _____

☐ If Other Tobacco Products, please specify (e.g., chewing tobacco):_____ Amount Per Day _____ Start Year (year) _____ End Year _____

Have you ever been diagnosed with chronic obstructive pulmonary disease ("COPD")? ☐ Yes ☐ No

If yes, please attach all documents regarding such diagnosis and explain the nature of the diagnosis: _____

_____

_____

3. Information Regarding Chest X-Ray

Please check the box next to the applicable location where your chest x-ray was taken (check one):

☐ Mobile laboratory ☐ Job site ☐ Union Hall ☐ Doctor office ☐ Hospital ☐ Other: _____

Address where chest x-ray taken: _____

4. Information Regarding Chest X-Ray Reading

Date of Reading: _____ **ILO score:** _____

Name of B-Reader: _____ **B-Reader's Daytime Telephone Number:** _____

B-Reader's Mailing Address: _____
Address City State/Province Zip/Postal Code

With respect to your relationship to the b-reader, check all applicable boxes:

Did you pay for the services performed by the reader? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the reader? ☐Yes ☐No

Was the reader referred to you by counsel? ☐Yes ☐No

Did the reader have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the reader certified by the National Institute of Occupational Safety and Health at the time of the reading? ☐ Yes ☐ No

5. Information Regarding Pulmonary Function Test:

Date of Test: _____ **Total Lung Capacity (TLC): ___% of predicted**

List your height in feet and inches when test given:_____ **Forced Vital Capacity (FVC): ____% of predicted**

List your weight in pounds when test given:_____ **FEV1/FVC Ratio: ____% of predicted**

Name of Doctor Performing Test (if applicable): _____ **Doctor's Specialty:** _____

Name of Clinician Performing Test (if applicable): _____

Testing Doctor or Clinician's Mailing Address: _____
Address City State/Province Zip/Postal Code

Testing Doctor or Clinician's Daytime Telephone Number: _____

Name of Doctor Interpreting Test: _____ **Doctor's Specialty:** _____

Interpreting Doctor's Mailing Address: _____

Interpreting Doctor's Daytime Telephone Number: _____

With respect to your relationship to the doctor or clinician who performed the pulmonary function test check all applicable boxes:

If the test was performed by a doctor, was the doctor your personal physician? ☐Yes ☐No

Did you or your insurance company pay for the services performed by the testing doctor and/or clinician? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the testing doctor or clinician? ☐Yes ☐No

Was the testing doctor or clinician referred to you by counsel? ☐Yes ☐No

Did the doctor or clinician have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the testing doctor certified as a pulmonologist or internist by the American Board of Internal Medicine at the time of the pulmonary function test? ☐ Yes ☐ No

With respect to your relationship to the doctor interpreting the results of the pulmonary function test check all applicable boxes:

Was the doctor your personal physician? ☐Yes ☐No

Did you or your insurance company pay for the services performed by the doctor? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the doctor? ☐Yes ☐No

Was the doctor referred to you by counsel? ☐Yes ☐No

Did the doctor have a financial or social relationship (direct or indirect) with your legal counsel? ☐Yes ☐No

Was the doctor interpreting the pulmonary function test results certified as a pulmonologist or internist by the American Board of Internal Medicine at the time the test results were reviewed? ☐ **Yes** ☐ **No**

6. Information Regarding Pathology Reports:

Date of Pathology Report: _____ **Findings:** _____

Name of Doctor Issuing Report: _____ **Doctor's Specialty:** _____

Doctor's Mailing Address: _____
Address City State/Province Zip/Postal Code

Doctor's Daytime Telephone Number: _____

With respect to your relationship to the doctor, check all applicable boxes:

Was the doctor your personal physician? ☐Yes ☐No

Did you or your insurance company pay the doctor for the services performed? ☐Yes ☐No

Were you required to retain counsel in order to receive any of the services performed by the doctor? ☐Yes ☐No

Was the doctor referred to you by counsel? ☐Yes ☐No

Did the doctor have a financial or social relationship with your legal counsel? ☐Yes ☐No

Was the doctor certified as a pathologist by the American Board of Pathology at the time of the diagnosis? ☐ **Yes** ☐ **No**

7. If alleging Other Cancer, please mark the box(es) next to the applicable primary cancer(s) being alleged:

☐ colon ☐ pharyngeal ☐ esophageal ☐ laryngeal ☐ stomach cancer ☐ other, please specify _____

8. If alleging Other Asbestos Diseases, please describe the diagnosis: _____

_____

9. Have you received medical treatment from a doctor for the condition alleged? ☐ Yes ☐ No

If yes, please complete the following:

Name of Treating Doctor: _____ **Treating Doctor's Specialty:** _____

Treating Doctor's Mailing Address: _____
Address City State/Province Zip/Postal Code

Treating Doctor's Daytime Telephone number: _____

Were you required to retain counsel in order to receive any of the services performed by the doctor? ☐**Yes** ☐**No**

APPENDIX D

Additional Copies of Part III of the Questionnaire

PART III: EXPOSURE TO ASBESTOS-CONTAINING PRODUCTS

If you were exposed at more than one site where you claim exposure to asbestos-containing products, then complete a separate Part III for each applicable site.

a. EXPOSURE TO GRACE ASBESTOS-CONTAINING PRODUCTS

1. Site of Exposure:

Site Type: ☐ Residence ☐ Business

Name of Site: _____ **Site Owner:** _____

Location: _____
Address City State/Province Zip/Postal Code

2. Employer During Exposure: _____

3. Please include any unions of which you were a member during your employment: _____

4. List all Grace asbestos-containing products to which you claim exposure at the particular site. If additional space is needed, please use the additional copies of Part III in Appendix D to this Questionnaire to complete a separate Part III (a)(4) as needed.

a. **Products Attributed to Grace (Include type of product and product name):** _____

_____

b. **Basis for Identification of <u>each</u> Grace Product:** _____

_____

c. **Dates and Frequency (hours/day, days/year) of Exposure to <u>each</u> Product Attributed to Grace:** _____

_____

d. **If you were exposed as a result of your employment, please indicate the occupation and industry during exposure to <u>each</u> product (see instructions for occupation and industry codes):**

Occupation Code:____. If Code 58, specify _____ **Industry Code:** ____. If Code 118, specify _____

e. **Is your exposure a result of working in or around areas where Grace asbestos-containing products were being installed, mixed, removed or cut by others?** ☐Yes ☐No

If yes, please indicate your regular proximity to such areas: ☐ 1-5 ft. ☐ 6-15 ft. ☐ 16-30 ft. ☐ 31-50 ft. ☐ 51-100 ft. ☐ 100+ ft.

f. **During exposure to <u>each</u> Grace asbestos-containing product which, if any, of the following were you? (check all that apply)**

- ☐ A worker who personally mixed Grace asbestos-containing products
- ☐ A worker who personally removed or cut Grace asbestos-containing products
- ☐ A worker who personally installed Grace asbestos-containing products
- ☐ A worker at the site where Grace asbestos-containing products were being installed, mixed, removed or cut by others
- ☐ A worker in the work space where Grace asbestos-containing products were being installed, mixed, removed or cut by others
- ☐ If Other, please specify: _____

5. Are you asserting an injury caused by exposure to Grace asbestos-containing products through contact/proximity with another injured person? ☐ **Yes** ☐ **No**

If yes, complete questions 6 through 14 of this section. If no, please skip to Part III(b)

6. Please indicate the following information regarding the other injured person:

Name of Other Injured Person: _____

Gender: ☐ Male ☐ Female **Social Security Number:** _____ **Birth Date:** _____

7. What is your Relationship to Other Injured Person: ☐ **Spouse** ☐ **Child** ☐ **Other**

8. **Nature of Other Injured Person's Exposure to each Grace Asbestos-Containing Products:** _____

_____

9. **Dates Other Injured Person was Exposed to each Grace Asbestos-Containing Products: From:** _____ **To:** _____

10. **Other Injured Person's Basis for Identification of each Asbestos-Containing Product as Grace Product:** _____

_____

11. **Has the Other Injured Person filed a lawsuit related to his/her exposure?** ☐ **Yes** ☐ **No**

If yes, please provide caption, case number, file date, and court name for the lawsuit:

Caption: _____

Case Number: _____ **File Date:** _____

Court Name: _____

12. **Nature of Your Own Exposure to Grace Asbestos-Containing Product:** _____

_____

13. **Dates of Your Own Exposure to Grace Asbestos-Containing Product: From:** _____ **To:** _____

14. **Your Basis for Identification of Asbestos-Containing Product as Grace Product:** _____

_____

b. EXPOSURE TO OTHER ASBESTOS-CONTAINING PRODUCTS

1. **Site of Exposure:**

Site Type: ☐ Residence ☐ Business

Name of Site: _____ **Site Owner:** _____

Location: _____
Address City State/Province Zip/Postal Code

2. **Dates of Exposure to Non-Grace Asbestos-Containing Products:** From _____ To _____

3. **List all Non-Grace asbestos-containing products to which you claim exposure at the particular site. If additional space is needed, please use the additional copies of Part III in Appendix D to this Questionnaire to complete a separate Part III (b)(3) as needed.**

a. **Asbestos Containing Products Not Attributed to Grace (Include type of product and product name):** _____

_____

b. **Basis for Identification of each Non-Grace Asbestos Product:** _____

_____

c. **Dates and Frequency (hours/day, days/year) of Exposure to each Product Not Attributed to Grace:** _____

_____

d. **If you were exposed as a result of your employment, please indicate the occupation and industry during exposure to each product (see instructions for occupation and industry codes):**

Occupation Code:____. If Code 58, specify _____ **Industry Code:** ____. If Code 117, specify _____

e. **Is your exposure a result of working in or around areas where non-Grace asbestos-containing products were being installed, mixed, removed or cut by others?** ☐Yes ☐No

If yes, please indicate your regular proximity to such areas: ☐ 1-5 ft. ☐ 6-15 ft. ☐ 16-30 ft. ☐ 31-50 ft. ☐ 51-100 ft. ☐ 100+ ft.

f. During exposure to <u>each</u> non-Grace asbestos-containing products which, if any, of the following were you? (check all that apply)

- ☐ A worker who personally mixed Non-Grace asbestos-containing products
- ☐ A worker who personally removed or cut Non-Grace asbestos-containing products
- ☐ A worker who personally installed Non-Grace asbestos-containing products
- ☐ A worker at the site where Non-Grace asbestos-containing products were being installed, mixed, removed or cut by others
- ☐ A worker in the work space where Non-Grace asbestos-containing products were being installed, mixed, removed or cut by others
- ☐ If Other, please specify:_____

PART III: EXPOSURE TO ASBESTOS-CONTAINING PRODUCTS

If you were exposed at more than one site where you claim exposure to asbestos-containing products, then complete a separate Part III for each applicable site.

a. EXPOSURE TO GRACE ASBESTOS-CONTAINING PRODUCTS

1. Site of Exposure:

Site Type: ☐ Residence ☐ Business

Name of Site: _____ **Site Owner:** _____

Location: _____
Address City State/Province Zip/Postal Code

2. Employer During Exposure: _____

3. Please include any unions of which you were a member during your employment: _____

4. List all Grace asbestos-containing products to which you claim exposure at the particular site. If additional space is needed, please use the additional copies of Part III in Appendix D to this Questionnaire to complete a separate Part III (a)(4) as needed.

a. Products Attributed to Grace (Include type of product and product name): _____

_____

b. Basis for Identification of <u>each</u> Grace Product: _____

_____

c. Dates and Frequency (hours/day, days/year) of Exposure to <u>each</u> Product Attributed to Grace: _____

_____

d. If you were exposed as a result of your employment, please indicate the occupation and industry during exposure to <u>each</u> product (see instructions for occupation and industry codes):

Occupation Code:____. If Code 58, specify _____ **Industry Code:** ____. If Code 118, specify _____

e. Is your exposure a result of working in or around areas where Grace asbestos-containing products were being installed, mixed, removed or cut by others? ☐ Yes ☐ No

If yes, please indicate your regular proximity to such areas: ☐ 1-5 ft. ☐ 6-15 ft. ☐ 16-30 ft. ☐ 31-50 ft. ☐ 51-100 ft. ☐ 100+ ft.

f. During exposure to <u>each</u> Grace asbestos-containing product which, if any, of the following were you? (check all that apply)

☐ A worker who personally mixed Grace asbestos-containing products

☐ A worker who personally removed or cut Grace asbestos-containing products

☐ A worker who personally installed Grace asbestos-containing products

☐ A worker at the site where Grace asbestos-containing products were being installed, mixed, removed or cut by others

☐ A worker in the work space where Grace asbestos-containing products were being installed, mixed, removed or cut by others

☐ If Other, please specify: _____

5. Are you asserting an injury caused by exposure to Grace asbestos-containing products through contact/proximity with another injured person? ☐ **Yes** ☐ **No**

If yes, complete questions 6 through 14 of this section. If no, please skip to Part III(b)

6. Please indicate the following information regarding the other injured person:

Name of Other Injured Person: _____

Gender: ☐ Male ☐ Female **Social Security Number:** _____ **Birth Date:** _____

7. What is your Relationship to Other Injured Person: ☐ **Spouse** ☐ **Child** ☐ **Other**

8. **Nature of Other Injured Person's Exposure to each Grace Asbestos-Containing Products:** _____

_____

9. **Dates Other Injured Person was Exposed to each Grace Asbestos-Containing Products: From:** _____ **To:** _____

10. **Other Injured Person's Basis for Identification of each Asbestos-Containing Product as Grace Product:** _____

_____

11. **Has the Other Injured Person filed a lawsuit related to his/her exposure?** ☐ **Yes** ☐ **No**

If yes, please provide caption, case number, file date, and court name for the lawsuit:

Caption: _____

Case Number: _____ **File Date:** _____

Court Name: _____

12. **Nature of Your Own Exposure to Grace Asbestos-Containing Product:** _____

_____

13. **Dates of Your Own Exposure to Grace Asbestos-Containing Product: From:** _____ **To:** _____

14. **Your Basis for Identification of Asbestos-Containing Product as Grace Product:** _____

_____

b. EXPOSURE TO OTHER ASBESTOS-CONTAINING PRODUCTS

1. **Site of Exposure:**

Site Type: ☐ Residence ☐ Business

Name of Site: _____ **Site Owner:** _____

Location: _____
Address City State/Province Zip/Postal Code

2. **Dates of Exposure to Non-Grace Asbestos-Containing Products:** From _____ To _____

3. **List all Non-Grace asbestos-containing products to which you claim exposure at the particular site. If additional space is needed, please use the additional copies of Part III in Appendix D to this Questionnaire to complete a separate Part III (b)(3) as needed.**

a. **Asbestos Containing Products Not Attributed to Grace (Include type of product and product name):** _____

_____

b. **Basis for Identification of each Non-Grace Asbestos Product:** _____

_____

c. **Dates and Frequency (hours/day, days/year) of Exposure to each Product Not Attributed to Grace:** _____

_____

d. **If you were exposed as a result of your employment, please indicate the occupation and industry during exposure to each product (see instructions for occupation and industry codes):**

Occupation Code:____. If Code 58, specify _____ **Industry Code:** ____. If Code 117, specify _____

e. **Is your exposure a result of working in or around areas where non-Grace asbestos-containing products were being installed, mixed, removed or cut by others?** ☐Yes ☐No

If yes, please indicate your regular proximity to such areas: ☐ 1-5 ft. ☐ 6-15 ft. ☐ 16-30 ft. ☐ 31-50 ft. ☐ 51-100 ft. ☐ 100+ ft.

f. During exposure to <u>each</u> non-Grace asbestos-containing products which, if any, of the following were you? (check all that apply)

- ☐ A worker who personally mixed Non-Grace asbestos-containing products
- ☐ A worker who personally removed or cut Non-Grace asbestos-containing products
- ☐ A worker who personally installed Non-Grace asbestos-containing products
- ☐ A worker at the site where Non-Grace asbestos-containing pr were being installed, mixed, removed or cut by others
- ☐ A worker in the work space where Non-Grace asbestos-conta products were being installed, mixed, removed or cut by othe
- ☐ If Other, please specify:_____

APPENDIX E

Additional Copies of Part V of the Questionnaire

PART V: LITIGATION AND CLAIMS REGARDING ASBESTOS AND/OR SILICA

a. LITIGATION

1. **Have you ever been a plaintiff in a lawsuit regarding asbestos or silica?** ☐ Yes ☐ No

   If yes, please complete the rest of this Part V(a) for each lawsuit.

2. **Please provide the caption, case number, file date, and court name for the lawsuit you filed**

   Caption: _____

   Case Number: _____ **File Date:** _____

   Court Name: _____

3. **Was Grace a defendant in the lawsuit?** ☐ Yes ☐ No

4. **Was the lawsuit dismissed?** ☐ Yes ☐ No

   If yes, please provide the basis for dismissal of the lawsuit? _____

   _____

   _____

5. **Has a judgment or verdict been entered?** ☐ Yes ☐ No

   If yes, please indicate verdict amount and defendant(s): _____

   _____

   _____

6. **Was a settlement agreement reached in this lawsuit?** ☐ Yes ☐ No

   If yes, please (a) indicate the settlement amount and (b) describe the terms of the settlement and the applicable defendants:

   a. Settlement Amount: _____

   b. Terms of the settlement (including any payments) and the applicable defendants: _____

   _____

7. **Were you deposed in this lawsuit?** ☐ Yes ☐ No

   If yes, please attach a copy of your deposition to this Questionnaire.

b. CLAIMS

1. **Have you ever asserted a claim regarding asbestos and/or silica, including but not limited to a claim against an asbestos trust (other than a formal lawsuit in court)?** ☐ Yes ☐ No

   If yes, please complete the rest of Part V(b) for each claim. If no, please skip to Part VI.

2. **Date the claim was submitted:** _____

3. **Person or entity against whom the claim was submitted:** _____

4. **Description of claim:** _____

   _____

   _____

5. **Was claim settled?** ☐ Yes ☐ No

6. **Please indicate settlement amount:** _____

7. **Was the claim dismissed or otherwise disallowed or not honored?** ☐ Yes ☐ No

   If yes, provide the basis for dismissal of the claim: _____

   _____

PART V: LITIGATION AND CLAIMS REGARDING ASBESTOS AND/OR SILICA

a. LITIGATION

1. **Have you ever been a plaintiff in a lawsuit regarding asbestos or silica?** ☐ Yes ☐ No

   If yes, please complete the rest of this Part V(a) for each lawsuit.

2. **Please provide the caption, case number, file date, and court name for the lawsuit you filed**

   Caption: _____

   Case Number: _____ **File Date:** _____

   Court Name: _____

3. **Was Grace a defendant in the lawsuit?** ☐ Yes ☐ No

4. **Was the lawsuit dismissed?** ☐ Yes ☐ No

   If yes, please provide the basis for dismissal of the lawsuit? _____

   _____

   _____

5. **Has a judgment or verdict been entered?** ☐ Yes ☐ No

   If yes, please indicate verdict amount and defendant(s): _____

   _____

   _____

6. **Was a settlement agreement reached in this lawsuit?** ☐ Yes ☐ No

   If yes, please (a) indicate the settlement amount and (b) describe the terms of the settlement and the applicable defendants:

   a. Settlement Amount: _____

   b. Terms of the settlement (including any payments) and the applicable defendants: _____

   _____

7. **Were you deposed in this lawsuit?** ☐ Yes ☐ No

   If yes, please attach a copy of your deposition to this Questionnaire.

b. CLAIMS

1. **Have you ever asserted a claim regarding asbestos and/or silica, including but not limited to a claim against an asbestos trust (other than a formal lawsuit in court)?** ☐ Yes ☐ No

   If yes, please complete the rest of Part V(b) for each claim. If no, please skip to Part VI.

2. **Date the claim was submitted:** _____

3. **Person or entity against whom the claim was submitted:** _____

4. **Description of claim:** _____

   _____

   _____

5. **Was claim settled?** ☐ Yes ☐ No

6. **Please indicate settlement amount:** _____

7. **Was the claim dismissed or otherwise disallowed or not honored?** ☐ Yes ☐ No

   If yes, provide the basis for dismissal of the claim: _____

   _____

APPENDIX F

Authorization to Disclose Health Information

I hereby authorize the use or disclosure of my individually identifiable protected health information ("PHI") as described below for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities covered under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") identified below disclose full and complete PHI spanning the time period of my date of birth to the present, including the following: all medical records, correspondence, laboratory reports, notes, radiology films, pharmacy/prescription records, billing records, and insurance records. This authorization is effective only to the extent allowed under the applicable state law.

(Check One) ☐ This release specifically does not authorize you to release any records pertaining to any mental health, psychiatric, or psychological treatment without further express consent from me. The Debtor reserve the right to seek these additional records in the future.

☐ This release specifically does authorize you to release any records pertaining to any mental health, psychiatric, or psychological treatment without further express consent from me.

Patient Name: _____

Patient SSN: _____ Patient Date of Birth: _____

I authorize you to release the PHI to any employee, agent or lawyer of the Debtors. This authorization is limited to the release of PHI; it specifically does not authorize any persons/organizations authorized to make disclosures to discuss my PHI, medical care or treatment with any employee, agent or lawyer of the Debtors.

Persons/Organizations Authorized to Make the Requested Disclosures

- I understand that I have the right to revoke this authorization at any time by writing to the Debtors and/or my health care providers listed above. I understand, however, that actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I understand that this authorization is voluntary and that once this information has been disclosed it may be subject to re-disclosure and would no longer be protected by federal privacy regulations.
- I understand that the health care providers to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign this authorization.
- Any facsimile or photocopy of this authorization shall authorize you to release the records described herein.

Signature: _____ Date: _____

If the Authorization is signed by a Personal Representative of the Individual, please provide a description of such representative's authority to act for the individual: _____